STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Rockville General Hospital
31 Union Street
Rockville CT 060606
M:

Signature of FLIS Staff

SN
BFS
Pamela Barlow

Licensure Category:

General Hospital

Licensed Bed Bassinet Capacity: 102 ~~46~~

Census: 47

Date(s) of onsite inspection: 3/19, 3/20, 3/21/2018, 3/22/18

Date(s) additional information obtained: _____

Personnel contacted: VP/Administrator Daniel DelGallo VP Quality/Safety Kathleen Davis

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [ ] *Renewal* [X] *Other (e.g.strikes):* Validation

[X] Visit **OR** Revisit for the purpose of follow-up to Violation Letter 7/20/16 POC

[X] See Complaint Investigation # 22927, 21567, 21068, 21110

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 4/18/18

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[X] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: SN **DATE OF REPORT:** 3/22/18

[X] Approval for issuance of license granted by: SN **DATE:** 3/22/18
Supervisor/Title

ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

Accepted
4/26/18
SHN/DK

April 20, 2018

Susan H. Newton, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue – MS # 12HSR
P.O. Box 340308
Hartford, CT 06134

Dr. Ms. Newton,

Pursuant to the Department of Health's letter of April 18, 2018, relating to the visits made to Rockville General Hospital, which concluded on March 22, 2018, a detailed Plan of Correction is attached to address the alleged violations.

The filing of this does not constitute any admission as to any of the alleged violations set forth in the statement of deficiencies. The Implementation Plan is being filed as evidence of the facility's continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

Please contact Kathleen Davis, Vice President of Quality & Safety, at (860) 533-3432, with any questions or concerns.

Respectfully,

Michael Collins
Chief Executive Officer

cc: Kathleen Davis

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 19, 2018

Mr. Daniel DelGallo, Administrator
Rockville General Hospital
31 Union Street
Rockville, CT 06066

Dear Mr. DelGallo:

This is an AMENDED edition of the violation letter originally dated April 28, 2018.

Unannounced visits were made to Rockville General Hospital concluding on March 22, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensure inspection and a follow up to plan of correction violation letter dated July 20, 2016.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **May 2, 2018** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: March 19, 20, 21 and 22, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

An office conference has been scheduled for **May 17, 2018** at **2:00 PM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-8018.

Respectfully,

Susan H. Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:jf

Complaints #22927, #21567, #21068 and #21110

DATES OF VISIT: March 19, 20, 21 and 22, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (e) Nursing service (1).

1. Based on a review of the clinical record and policy review, the hospital failed to ensure that a contracted dialysis company provided quality care to one sampled hemodialysis patient (Patient #13) in that the physician's order was not comprehensive to include the blood flow rate (BFR) and the dialysate flow rate (DFR) prior to administration. The findings include the following:
   a. Review of Patient #13's clinical record indicated the patient was admitted on 1/16/18 for chest pain. The patient was also receiving hemodialysis three times a week. Review of the clinical record on 3/19/18 with the Quality representative identified a physician's order dated 1/17/18 that directed three hour hemodialysis treatments utilizing a 2 potassium and 2.5 calcium bath with blood flow (BFR) and dialysate flow rate (DFR) parameters as "max". The physician's order failed to direct a specific dose based on the specific needs/goals of the patient.
      i. Review of the hemodialysis treatment sheets dated 2/21/18 indicated a BFR of 200 ml/min and a DFR of 600 ml/min, the flow sheet dated 2/26/18 indicated a BFR of 400 ml/min and a DFR of 600 ml/min.
      ii. The flow sheets dated 2/23/18, 3/9/18, 3/12/18, 3/14/18, 3/16/18 and 3/19/18 identified a BFR of 300-350 ml/min and a DFR of 600 ml/min was administered.
      iii. The flow sheet dated 2/28/18, 3/2/18, 3/5/18, and 3/7/18, identified that a BFR of 300 ml/min and a DFR of 800 ml/min was administered.

      The hospital failed to ensure that hemodialysis was administered based on a specific physician's order.

      Review of the Prescription verification procedure indicated that all staff will verify the dialysis orders to ensure that the patient receives a safe and effective treatment. Staff should verify and document in part the prescribed dialyzer and blood flow rate to ensure that the patient prescription is initiated prior to

      Action Plan: The Meditech order "Dialysis-Hemodialysis Treatment Order" will be revised to reflect the specific Blood Flow Rate (BFR) and Dialysate Blood Flow Rate (DFR). The option for "Maximal" in fields for Blood Flow Rate (BFR) will be removed, look up options will be updated to only include specific rates for BFR, and there will be a message under this field regarding "when it is not possible to obtain the ordered BFR, refer to the Davita protocol". This protocol will be linked to the order. The order set will also be revised including removal of the option for "Maximal" in the Dialysate Flow Rate Field (DFR), and to only have specific DFR rates to select from, as well as the option for "sequential" for ultra-filtration (fluid removal only). IT request sent 4/16/18. Changes effective 4/20/18. The Davita Dialysis nursing staff and nephrology providers will be educated on these changes- 4/20/18. The Davita Dialysis nursing staff will be re-educated on verifying the hemodialysis orders prior to

initiating treatment and documenting, in part, the prescribed dialyzer and blood flow rates by 4/20/18.
Audit: 5 patient records monthly x3 months to ensure documentation of dialysis and BFRs on patient flowsheets match the hemodialysis orders in Meditech
Person(s) Responsible: Davita Hospital Services Administrator, Nurse Manager BII
Completion Date: July 31, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (e) Nursing service (1) and/or Connecticut General Statues Section 46a-152.

2. *Based on clinical record review and policy review, for one of four patients' reviewed for restraints (Patient #4), the hospital failed to ensure that a specific physician's order was written for restraint application in accordance with the hospital's protocol. The finding includes the following:
    a. Review of Patient #4's clinical record indicated that the patient was admitted on 3/9/18 with left shoulder pain, and overall physical decline. The patient was noted to have a dislocated left shoulder and a fracture of the greater tuberosity of the left humerus. Review of the orthopedic Physician Assistant's (PA) note dated 3/18/18 at 12:45 PM indicated that the plan was to continue conservative treatment of the left shoulder dislocation and fracture and that the patient's left arm should remain in the sling at all times with no range of motion to the left shoulder.

    The record reflected that the patient was extubated on 3/18/18. Review of the physician's order dated 3/18/18 directed "restrain patient using the least restrictive method per protocol". The physician/Licensed Independent Practitioner (LIP) order failed to direct the type of restraint to be utilized. Review of the restraint monitoring flow sheet indicated that the patient was placed in bilateral wrist restraints by the RN absent a specific order.

    Review of the medical line, dressing and Tube Protection Protocol indicated if a restraint is needed the nurse must notify the Physician or APRN and obtain an order for the restraint as soon as possible. The order must indicate the behavior requiring the restraint, type of restraint and criteria for discontinuation.

    Action Plan: Per policy Medical Line, Dressing and Tube Protection CPM 14.17, "the initial order must indicate a time limit for the duration of the order taking into consideration the following: a. behavior requiring the use of restraint, b. type of restraint and c. criteria for discontinuation
    The nurse documents the type of restraint based upon the least restrictive device necessary to prevent removal of the medical equipment used. In this case the restraint order was obtained from the intensivist. The Physician Assistant (orthopedic consultant) was not notified of the restraint in this case.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Nursing staff will be educated to ensure that consulting specialists be notified of the need for restraints if restraining the patient limb(s) may interfere with prescribed treatment and the need to document all alternatives tried prior to restraint application by 4/30/18.
This particular order **did** include the behaviors observed requiring the restraint. Our policy does not require the criteria for discontinuation to be included in the order, however, the nurse continually assesses the patient's readiness for discontinuation of restraints as reflected in the documentation on the nursing flow sheet every two hours.
Audits: will be conducted in the Rockville ICU on 5 patients requiring limb(s) restraints/month for 3 months for patients whose prescribed treatment requires limb mobility restrictions for the presence of documentation that the consultant specialist was made aware and is in agreement with the restraint method. Audits will also ensure alternatives tried will be documented. If inadequate sample size regarding the patient with limb mobility restrictions, audits will be completed by asking staff members randomly to describe the process verbally.
Person(s) Responsible: Nurse Manager, ICU
Completion Date: July 31, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or Connecticut General Statues Section 46a-152.

3. Based on clinical record review, interviews with staff and policy review for 1 of 4 patients' reviewed for restraint and seclusion (Patient #1), the hospital failed to ensure that seclusion was discontinued at the earliest possible time. The findings include:
    a. Patient #1 was admitted on 1/29/18 with diagnoses of Post Traumatic Stress Disorder (PTSD) and bulimia nervosa. A physician order for seclusion dated 2/4/18 at 1:00 PM identified Patient #1 exhibited violent and aggressive behaviors, was screaming, threatening, not contracting for safety and was a danger to self. Criteria for discontinuation included calm behavior and verbalization of a desire to cooperate. Patient #1 was identified as willingly going into seclusion. Review of the restraint flow sheet identified that Patient #1 was in seclusion from 1:00 PM to 3:00 PM. However, between 1:30 PM and 3:00 PM Patient #1 was identified as calm, talking to staff and sitting or laying down but remained in seclusion. Review of nursing documentation in this time frame failed to identify that Patient #1 was anything other than calm, as identified on the flow sheet.

    Interview with Clinical Coordinator #1 on 3/19/18 at 10:40 AM identified that she recalled that on 2/4/18 Patient #1 continued to be agitated, yelling and threatening between 1:30 PM and 3:00 PM which was not documented in the monitoring sheet and should have been.

    The hospital policy for restraint/seclusion identified that that a restraint must be changed to a less restrictive method as soon as possible and that assessment for discontinuation of restraints/seclusion must be on-going.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Action Plan: Eating Disorder Unit clinical staff will be educated via an SBAR and blast email regarding documentation requirements for restraint/seclusion including the need to document alternatives tried, behavior warranting the restraint/seclusion, type of restraint, patient's response to the restraint/seclusion, criteria for discontinuation at the earliest possible time, rationale for continued use and accurate documentation on the restraint flow sheet completing each section in the required timeframes as noted on the form. Education to be completed by 4/30/18.
Audit: A random audit of 5 restraint/seclusion records per month x 3 months for accurate and complete documentation related to alternatives tried, behavior warranting the restraint/seclusion, type of restraint, patient's response to the restraint/seclusion, criteria for discontinuation at the earliest possible time, rationale for continued use and accurate documentation on the restraint flow sheet completing each section in the required timeframes as noted on the form.
Person(s) Responsible: Nurse Manager, Eating Disorder Unit
Completion Date: July 31, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or Connecticut General Statues Section 46a-152.

4. Based on clinical record review, interview and policy review, for one of four patients' reviewed for restraints (Patient #4) the hospital failed to ensure that alternatives were documented as attempted prior to the initiation of restraints. The finding includes the following:
   a. Review of Patient #4's clinical record indicated that the patient was admitted on 3/9/18 with left shoulder pain, and overall physical decline. The patient was noted to have a dislocated left shoulder and a fracture of the greater tuberosity of the left humerus. Review of the orthopedic PA note dated 3/18/18 at 12:45 PM indicated that the plan was to continue conservative treatment of the left shoulder dislocation and fracture and that the patient's left arm should remain in the sling at all times with no range of motion to the left shoulder.

      The record reflected that the patient was extubated on 3/18/18. Review of the monitoring flow sheet dated 3/18/18 at 3:00 PM identified that the patient was in bilateral wrist restraints. Review of the clinical record indicated that for alternatives attempted identified that the patient's "room near the nursing station" however the patient was in the ICU and all of the rooms are located around the nursing station. The clinical record failed to documentation of the behaviors that warranted restraints and/or alternatives tried prior to the application of bilateral wrist restraints. Interview with the Charge Nurse on 3/19/18 at 10:30 AM stated that the patient was pulling lines and initially the patient's right arm was secured however the patient kept moving the left arm therefore that arm was subsequently secured. Interview with the Orthopedic PA on 3/20/18 at 1:15 PM stated that she was on duty on 3/18/18 and did not receive a call that the patient was going to be restrained and that based on his/her injury the left arm should not have been restrained. The PA further stated that if a restrain was required, securing the patient's arm to his/her trunk (pappoosing) would have been ideal.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of the facility policy indicated alternatives to restraints must be considered and determined to be ineffective in the protecting the patient prior to the application of restraints.

Action Plan: Per policy Medical Line, Dressing and Tube Protection CPM 14.17, "the initial order must indicate a time limit for the duration of the order taking into consideration the following: a. behavior requiring the use of restraint, b. type of restraint and c. criteria for discontinuation
The nurse documents the type of restraint based upon the least restrictive device necessary to prevent removal of the medical equipment used. In this case the restraint order was obtained from the intensivist. The Physician Assistant (orthopedic consultant) was not notified of the restraint in this case.
Nursing staff will be educated to ensure that consulting specialists be notified of the need for restraints if restraining the patient limb(s) may interfere with prescribed treatment and the need to document all alternatives tried prior to restraint application by 4/30/18.
This particular order **did** include the behaviors observed requiring the restraint. Our policy does not require the criteria for discontinuation to be included in the order, however, the nurse continually assesses the patient's readiness for discontinuation of restraints as reflected in the documentation on the nursing flow sheet every two hours.
Audits: will be conducted in the Rockville ICU on 5 patients requiring limb(s) restraints/month for 3 months for patients whose prescribed treatment requires limb mobility restrictions for the presence of documentation that the consultant specialist was made aware and is in agreement with the restraint method. Audits will also ensure alternatives tried will be documented. If inadequate sample size regarding the patient with limb mobility restrictions, audits will be completed by asking staff members randomly to describe the process verbally.
Person(s) Responsible: Nurse Manager, ICU
Completion Date: July 31, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or Connecticut General Statues Section 46a-152.

5. Based on clinical record review, interviews with staff and policy review for 1 of 4 patients reviewed for restraint and seclusion (Patient #2), the hospital failed to ensure that the intervention and patient response to the intervention of seclusion and/or 4-point restraint was documented. The findings include:
    a. Patient #2 was admitted on 2/7/18 with diagnoses of Post Traumatic Stress Disorder (PTSD), major depression and anorexia nervosa. A physician order for 4-point restraint dated 3/1/18 at 10:10 PM identified Patient #2 exhibited violent and aggressive behaviors and was refusing necessary medical treatment. The restraint order was for a duration of 4 hours. Criteria for discontinuation included calm behavior and verbalization of a desire to cooperate. Corresponding nursing notes identified Patient #2

was screaming and pushing staff and was placed in 4-point restraints to complete the medical treatment. Despite a physician order and nursing documentation identifying Patient #2 was placed in 4-point restraints, review of the restraint monitoring flow sheet failed to identified that Patient #2 was in restraints. The flow sheet indicated that Patient #2 was on 1:1 supervision and was pacing, agitated, struggling, and in bed quiet and/or sleeping in this time frame. In addition, a nurse's note dated 3/1/18 identified the Patient #2 exhibited aggressive, combative and violent behaviors, was a danger to self and others, and was placed in seclusion from 10:48 PM to 10:53 PM. Review of the restraint/seclusion monitoring flow sheet failed to identify that Patient #2 was in seclusion.

Interview with Clinical Coordinator #1 on 3/19/18 at 10:45 AM identified that Patient #2 was in 4-point restraints on the night of 3/1/18 into the morning of 3/2/18 and that staff should have documented on the restraint flow sheet that the patient was in restraints and/or seclusion and should have documented appropriate interventions.

The hospital restraint/seclusion policy identified that the restraint flow sheet was to include documentation of proper application of a device, limb release/range of motion, respiratory/circulatory/sensation status, skin integrity and care delivery codes.

Action Plan: Eating Disorder Unit clinical staff will be educated via an SBAR and blast email regarding documentation requirements for restraint/seclusion including the need to document alternatives tried, behavior warranting the restraint/seclusion, type of restraint, patient's response to the restraint/seclusion, criteria for discontinuation at the earliest possible time, rationale for continued use and accurate documentation on the restraint flow sheet completing each section in the required timeframes as noted on the form. Education to be completed by 4/30/18.
Audit: A random audit of 5 restraint/seclusion records per month x 3 months for accurate and complete documentation related to alternatives tried, behavior warranting the restraint/seclusion, type of restraint, patient's response to the restraint/seclusion, criteria for discontinuation at the earliest possible time, rationale for continued use and accurate documentation on the restraint flow sheet completing each section in the required timeframes as noted on the form.
Person(s) Responsible: Nurse Manager, Eating Disorder Unit
Completion Date: July 31, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1)

6. *Based on a review of staffing schedules, review of the staffing plan, review of facility documentation, and interviews, the facility failed to ensure that adequate staffing was maintained in the ICU (intensive care unit). The findings include:
   a. Review of the ICU assignment sheet dated 3/12/18 on the night shift (11:00 PM to 7:00 AM) indicated that the unit had a census of 8 patients with 3 registered nurses (RN) and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1 certified nursing assistant (CNA) working. The staffing matrix directed that for a census of 8 patients (all 3 shifts) staffing should include 4 licensed staff and 1 CNA.

b. The assignment sheets dated 3/11/18 and 3/10/18 indicated that on the night shift there were 3 RN's for 8 patients.
c. The assignment sheet dated 3/7/18 indicated that on the evening shift (3:00 PM to 11:00 PM) there were 3 RN's and no CNA for 8 patients.
d. The assignment sheet dated 3/8/18 and 3/2/18 indicated that for the night shift there were 6 patients and 2 RN's. The evening shift on 3/8/18 also had 6 patients and 2 RN's. Review of the matrix directed that for a census of 6 patients staffing should include 3 licensed staff.
e. The assignment sheet dated 3/6/18 indicated that for the day (7:00 AM to 3:00 PM) and evening shift there were 9 patients in the ICU with 3 RN's. Review of the matrix directed that for a census of 9 patients staffing should include 4 licensed staff.

Review of the assignment sheets and interview with the Nurse Manager on 3/20/18 at 11:40 AM stated the staffing "matrix" is more of a suggestion and is submitted to the state. The Manager further stated that staffing is based on acuity however the facility failed to have an acuity policy and/or system in place that determined the patient's acuity status. The Manager indicated that staff may have had three or more patients if the patients were "boarders" but staff would never have more than two patients at a time if they are on ventilators.

f. Review of the assignment sheet dated 3/12/18 with the Manager on 3/20/18 at 11:40 AM indicated that 1 RN was assigned to three (3) patients, two (2) of which required mechanical ventilation. The Manager stated that there have been staffing issues in the ICU however she has recently hired 4 new RN's.
g. Review of the assignment sheets dated 3/11/18 evening shift, 3/10/18 day and evening shift, and 3/8/18 night and evening shift identified that one RN was assigned to (3) three patients, two (2) of which required mechanical ventilation.

Action Plan: The ICU staffing plan is designed to allow for flexibility in staffing according to identified needs of the patients. Every attempt is made to maintain staffing ratios of one registered nurse for every two to three patients. In an attempt to maintain these staffing ratios during times of staffing vacancies or surges in census the following measures are/will be implemented:

1. Use of per diem floats
2. Float nurses from other areas and have them care for any "border" patient in ICU or patients that are ready for lower level of care (less acute)
3. Employee travel/agency nurses
4. Nurse manager, nurse educator to assist on unit
5. Use of supportive personnel-this includes health unit secretaries, transport personnel (day shift), use of sitters. Other supportive services include, pharmacists, physical therapists, respiratory therapist and nursing supervisor.
6. RN Orientees may be considered as staff *assistance*-based upon their level of experience and progress in orientation.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

7. Development of a staffing assignment sheet to indicate acuity of patients, so that assignments are created based on not only number of patients but complexity of patients. Depending on complexity a nurse may take up to 4 border patients, or those patients identified as being able to transfer to a lower level of care. Staffing assignment sheet to be implemented by 4/23/18.

Person(s) Responsible: Sr. VP Patient Care Services/Chief Nursing Officer
Completion Date: April 23, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1).

7. Based on a review of clinical records and policy review, for one of three patients reviewed for pain (Patient #3), the hospital failed to ensure the patient's level of pain was assessed in the ED in accordance with hospital policy. The finding includes the following:
   a. Patient #3 presented to the ED on 11/09/17 at 2:43 AM with the complaint of left shoulder pain. Although the patient's vital signs were obtained during triage, the patient's level of pain was not determined. A physician's note indicated that the patient had left shoulder pain for two months however failed to quantify the patient's level of pain. A shoulder x-ray was completed that was negative for a fracture and/or dislocation. Review of the clinical record identified that Dilaudid 1 mg IM was administered at 3:13 AM. The record failed to reflect the patient's level of pain prior to the administration of the medication and/or following the administration to determine the efficacy of the intervention. The patient was subsequently discharged at 4:15 AM.

      Review of the hospital policy directed that all patients will be assessed for their level of pain. The policy further indicated that the patient will be reassessed following an intervention to determine the effectiveness.

      Action Plan: The ED nursing staff will be educated on the need to assess all patients for pain, level of pain, starting at Triage, after any pain intervention(s), and prior to discharge. Reassessment of pain level, after intervention/treatment is also required. Education to be completed by 4/30/18.
      Audit: A random audit of 5 patient records per month x 3 months for the documentation of pain assessment, including level of pain, at triage, with treatment, and prior to discharge. Reassessment of pain level must be documented after treatment/intervention.
      Person(s) Responsible: Nurse Manager, ED
      Completion Date: July 31, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1).

8. Based on clinical record review, interviews with staff and policy review for 2 of 4 patients reviewed for restraint and seclusion (Patient #2), the hospital failed to ensure that restraint and

seclusion documentation the clinical record was complete and/or accurate. The findings include:

a. Patient #1 was admitted on 1/29/18 with diagnoses of Post Traumatic Stress Disorder (PTSD) and bulimia nervosa. A physician order for seclusion dated 2/4/18 at 1:00 PM identified Patient #1 exhibited violent and aggressive behaviors, was screaming, threatening, not contracting for safety and was a danger to self. Criteria for discontinuation included calm behavior and verbalization of a desire to cooperate. Patient #1 was identified as willingly going into seclusion. Review of the restraint flow sheet identified that Patient #1 was in seclusion from 1:00 PM to 3:00 PM. However, between 1:30 PM and 3:00 PM Patient #1 was identified as calm, talking to staff and sitting or laying down but remained in seclusion. Review of nursing documentation in this time frame failed to identify that Patient #1 was anything other than calm, as identified on the flow sheet.

   Interview with Clinical Coordinator #1 on 3/19/18 at 10:40 AM identified that she recalled that on 2/4/18 Patient #1 continued to be agitated, yelling and threatening between 1:30 PM and 3:00 PM which was not documented in the monitoring sheet and should have been.

b. Patient #2 was admitted on 2/7/18 with diagnoses of Post Traumatic Stress Disorder (PTSD), major depression and anorexia nervosa. A physician order for 4-point restraint dated 3/1/18 at 10:10 PM identified Patient #2 exhibited violent and aggressive behaviors and was refusing necessary medical treatment. The restraint order was for a duration of 4 hours. Criteria for discontinuation included calm behavior and verbalization of a desire to cooperate. Corresponding nursing notes identified Patient #2 was screaming and pushing staff and was placed in 4-point restraints to complete the medical treatment. Despite a physician order and nursing documentation identifying Patient #2 was placed in 4-point restraints, review of the restraint monitoring flow sheet failed to identified that Patient #2 was in restraints. The flow sheet indicated that Patient #2 was on 1:1 supervision and was pacing, agitated, struggling, and in bed quiet and/or sleeping in this time frame. In addition, a nurse's note dated 3/1/18 identified the Patient #2 exhibited aggressive, combative and violent behaviors, was a danger to self and others, and was placed in seclusion from 10:48 PM to 10:53 PM. Review of the restraint/seclusion monitoring flow sheet failed to identify that Patient #2 was in seclusion.

   Interview with Clinical Coordinator #1 on 3/19/18 at 10:45 AM identified that Patient #2 was in 4-point restraints on the night of 3/1/18 into the morning of 3/2/18 and that staff should have documented on the restraint flow sheet that the patient was in restraints and/or seclusion and should have documented appropriate interventions.

   The hospital restraint/seclusion policy identified that the restraint flow sheet was to include documentation of proper application of a device, limb release/range of motion, respiratory/circulatory/sensation status, skin integrity and care delivery codes.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Action Plan: Eating Disorder Unit clinical staff will be educated via an SBAR and blast email regarding documentation requirements for restraint/seclusion including the need to document alternatives tried, behavior warranting the restraint/seclusion, type of restraint, patient's response to the restraint/seclusion, criteria for discontinuation at the earliest possible time, rationale for continued use and accurate documentation on the restraint flow sheet completing each section in the required timeframes as noted on the form. Education to be completed by 4/30/18.
Audit: A random audit of 5 restraint/seclusion records per month x 3 months for accurate and complete documentation related to alternatives tried, behavior warranting the restraint/seclusion, type of restraint, patient's response to the restraint/seclusion, criteria for discontinuation at the earliest possible time, rationale for continued use and accurate documentation on the restraint flow sheet completing each section in the required timeframes as noted on the form.
Person(s) Responsible: Nurse Manager, Eating Disorder Unit
Completion Date: July 31, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (g) Pharmacy (1) and/or (L) Infection Control.

9. Based on review of hospital documentation related to compounding services the hospital failed to ensure required media fill testing and gloved finger tip testing for 1 of 5 staff members was completed according to USP 797. The findings include:
    a. During a review of pharmacy staff compounding competencies and United Stated Pharmacopeia (USP) 797 required testing, it was identified that Pharmacy Technician #10 had completed media fill testing and gloved fingertip testing in 2016 but had not completed the required annual testing in 2017.

    During an interview with the Pharmacy Director on 3/20/18 at 11:10 AM he/she indicated documentation could not be found that Pharmacy Technician #10 had completed the required annual testing and the Director of Pharmacy was sure it had not been completed in 2017 and should have been completed. The Pharmacy Director indicated the Pharmacist who had been responsible to oversee the competencies and required testing of the staff no longer was employed by the hospital however ultimately it was the Pharmacy Directors responsibility to ensure the testing was completed.

    The Hospital General Pharmacy Department Policy and Procedure indicated personnel preparing or dispensing sterile products must receive training and competency evaluation including aseptic technique and process simulation before beginning duties and at least annually.

    According to USP 797 Compounding personnel shall perform didactic review and pass written testing of aseptic manipulative skills, at least annually thereafter for low- and medium-risk level compounding, and semiannually for high-risk level compounding.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Action Plan: Immediately, upon becoming aware of this finding the technician was not permitted to work at RGH until the test was completed and the results were negative. Both tests were completed the following day, 3/21/18. Once the results were back from the 3 days of gloved fingertip test and the 14 days monitoring for media fill test results, the technician was permitted to work 4/4/18. All other staff had completed their 2018 IV competency with results that were negative.
Person(s) Responsible: Director, Pharmacy
Completion Date: April 4, 2018

Action Plan: Compounding personnel shall perform didactic review and pass written testing of aseptic manipulative skills, at least annually. Rockville only performs low and medium risk level compounding. A Healthstream educational module will be assigned annually. Staff to complete this by May 31, 2018 and annually thereafter.
Person(s) Responsible: Director, Pharmacy
Completion Date: May 31, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2) and/or (i) General (6).

10. *Based on a review of facility records and interview with the Hospital's Emergency Management Director, Engineering Director, Environmental Safety Officer, and the Chief Operating Officer of the Eastern Connecticut Health Network, the Hospital failed ensure that the condition of the physical plant and the overall hospital environment was developed and maintained in such a manner that the safety and well-being of patients are assured. The findings include the following:
    a. On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director, the Environmental Safety Officer, and the Chief Operating Officer of the Eastern Connecticut Health Network that identified the annual door inspection was not completed by 01/01/18 as required by S&C 17-38-LSC.
    b. The facility did not ensure that the required automatic sprinkler system was continuously maintained in reliable operating condition and was inspected and tested periodically, as required by section # 19.7.6 of the referenced "Life Safety Code". Cross reference CMS 2567 tags A724, E004, E 0030, E0031, E0037, E0037, E0042, K300, K311, K353 & K374.

Action Plan: a. The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will be reduced to yearly once approved by the Environment of Care Committee. The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
Person(s) Responsible: Director, Engineering Services
Completion Date: April 13, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Action Plan: b. The automatic sprinkler system is listed on the Life Safety Matrix to assure a reliable operating condition of the automatic sprinkler system.
Person(s) Responsible: Director, Engineering Services
Completion Date: April 16, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6) and/or (L) Infection Control.

11. *The facility failed to ensure that a water management plan in place to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD) as required by the Centers for Medicare and Medicaid services survey and certification letter S&C 17-30-ALL issued June 2, 2017 and as required by 42 CFR §482.42 for hospitals:
    a. "The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases."

    On 03/20/18 at 10:30 AM, the surveyor was not provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the facility had a comprehensive water management plan in place as required by S&C 17-30 ALL. The facility was in the process of securing contractors to survey the facility and develop their water management plan, however this has not been completed to date. The facility does have an active cooling tower maintenance and testing plan in place.

    Action Plan: In order to reduce Legionella risk in the healthcare facility's water systems and prevent cases and outbreaks of Legionnaires' disease, the Barclay Company has been contracted to assist in the development of a comprehensive water management plan that will be implemented pending test results.
    Person(s) Responsible: Director, Engineering Services
    Completion Date: June 30, 2018

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (g) Pharmacy (2) and/or (L) Infection Control.

12. Based on a review of Hospital documentation it was identified that the hospitals infection control committee did not consistently review required testing in the pharmacy compounding area. The findings include:
    a. A review of the monthly Infection Control Committee meeting minutes and/or communication with the Infection Control Committee dated November 2015 and November 2016 indicated the results of environmental monitoring of the pharmacy compounding area, conducted every 6 months, was reviewed. However the monthly

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Infection Control Committee meeting minutes and/or communication with the Infection Control Committee failed to identify the environmental monitoring results conducted in April 2016, April 2017 and October 2017 were reviewed by the committee.

Interview with the Director of Pharmacy on 3/19/19 at 9:00 AM, the Director of Pharmacy indicated he/she was a member of the Infection Control committee however reports from the pharmacy compounding area were not discussed in the meetings.

Interview with the Infection Prevention Nurse on 3/20/18 at 1:45 PM identified that rounds are conducted in the pharmacy and a review of environmental monitoring results was conducted with the pharmacists however the results had not been discussed in the Infection Control Committee meetings. He/she indicated the lack of reporting was recently identified as an issue during a separate agency review. The Infection Prevention Nurse indicated going forward he/she would gather the data pertaining to the pharmacy compounding area and present it at appropriate committee meetings.

The hospital Clean Room Environmental Testing policy indicated all results for viable testing will be shared with the Infection Control Committee.

Action Plan: All results for environmental monitoring in the Pharmacy clean room will be brought to the Infection Control Committee (ICC) for review. Testing and subsequent results of that testing is done every six months. The pharmacy representative will provide these monitoring results to the ICC upon the next meeting the ICC has scheduled after the monitoring results have been received. The monitoring reports will include the results of the viable and non-viable results of the pharmacy compounding area. The monitoring reports will also include the status of the laminar flow hoods and biological safety cabinet (BSC). Viable testing results for March 2018 sampling were reported at the Infection Control Committee on 3/27/18. The next viable sampling is scheduled to be completed in September 2018. The hoods will be tested on April 29, 2018 and again in October.
Person(s) Responsible: Director, Pharmacy
Completion Date: April 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

13. The facility failed to ensure that an emergency preparedness program was developed and maintained, and meets all of the requirements of Final Rule (81 FR 63860) Emergency Preparedness Requirements and §§482.15 ,Condition of Participation for Hospitals.

On 03/20/18 at 10:30 AM, the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer that was identified as being site specific, non-generic Emergency Preparedness Plan containing and addressing the following elements: Development of Communication Plan;

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Emergency Officials Contact Information; Methods for Sharing Information; Sharing Information on Occupancy/Needs; Family Notification; Emergency Preparedness Training Program including HICS.

Action Plan: The Emergency Preparedness plans are current and established. These plans will be reviewed and updated as needed every calendar year at the Environment of Care Committee Meeting and Emergency Management Committee Meeting.

Policy Number 300 (Emergency Management Plan) will be revised to be facility specific and will detail the required elements:
This plan will include the following elements:

- Policy and Organizational Statements
- Scope and Purpose
- Responsibilities
- Risk Assessment Process
- Communications
- Continuity of Operations
- Training and Testing Program
- Reporting of Exercise and Actual Events
- Annual Performance Measures

HICS training was provided 03/21/18
Person(s) Responsible: Director, Emergency Management
Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

14. The facility failed to ensure that an emergency preparedness communication plan that complies with Federal, State and local laws was developed and implemented. .

On 03/20/18 at 10:30 AM, the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer that didn't include Emergency Preparedness Plan call list containing and addressing the following elements: Names and contact information for the following: Staff, Entities providing services under arrangement, Patients' physicians, other hospitals

Action Plan: The Emergency Preparedness plans are current and established. These plans will be reviewed and updated as needed every calendar year at the Environment of Care Committee Meeting and Emergency Management Committee Meeting.

Policy Number 301 (Emergency Operations Plan) will be revised to have a specific communications plan, that is facility specific and will include, or detail the location of the following names and contact information:

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- Staff- included in the Everbridge Communication System
- Entities providing services under arrangement
- Patient's physicians- Medical Affairs submits these numbers to the Incident Command Center
- Facilities- in RPA Navigator and command center books
- Volunteers-Notified by the Communications Dept.
- This call list for the Incident Management Teams- in policy and available at switchboard

Person(s) Responsible: Director, Emergency Management
Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

15. The facility failed to ensure that an emergency preparedness communication plan that complies with Federal, State and local laws was developed and implemented.

    On 03/20/18 at 10:30 AM, the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer that didn't include Emergency Preparedness Plan call list that didn't include call lists and numbers for Federal, State, tribal, regional, and local emergency preparedness staff and or other sources of assistance

    Action Plan: The Emergency Preparedness plans are current and established. These plans will be reviewed and updated as needed every calendar year at the Environment of Care Committee Meeting and Emergency Management Committee Meeting.

    RPA Navigator will be updated and contact information provided to switchboard and command center that is facility specific and will include, or detail the location of the following names and contact information:

    - Federal, State, regional and local emergency preparedness staff as well as other sources of assistance - in RPA Navigator and command center books

    Person(s) Responsible: Director, Emergency Management
    Completion Date: June 1, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

16. The facility failed to ensure that an emergency preparedness training program was developed and maintained, and meets all of the requirements of Final Rule (81 FR 63860) Emergency Preparedness Requirements and §§482.15.

    On 03/20/18 at 10:30 AM, the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Safety Officer that identified all employees had not been trained on the facilities new Emergency Preparedness Plan and Emergency Preparedness Training Program including HICS; .

Action Plan: The EP Training Program includes:

- Initial training of staff is included in new employee orientation
- Training is provided at least annually via on-line learning system
- Documentation of training is maintained
- Staff demonstrated knowledge of emergency procedures via on-line learning system or documented facilitated discussion.

This training will be developed in a manner that takes into account the individual certified facility's site specific unique circumstances, patient population and services offered.

HICS training was provided: 3/21/18

Other Emergency Preparedness Training is scheduled for 5/21 & 5/22/18 for individuals consistent with their expected roles.

Online training for all staff will be reviewed and content ensured to provide site specific emergency preparedness training for annual education of all staff. Content will be updated by 6/30/18.
Person(s) Responsible: Director, Emergency Management
Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

17. The facility failed to ensure that an emergency preparedness program was developed and maintained, and meets all of the requirements of Final Rule (81 FR 63860) Emergency Preparedness Requirements and §§482.15.

    On 03/20/18 at 10:30 AM, the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the Rockville Hospital, a hospital within the Eastern Connecticut Health Network was utilizing a integrated emergency preparedness plan that lacked a site specific communication plan; emergency officials contact information; methods for sharing information; and documentation that all hospitals within the network participated in the development of the plan

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Action Plan: The Emergency Preparedness plans are current and established. These plans will be reviewed and updated as needed every calendar year at the Environment of Care Committee Meeting and Emergency Management Committee Meeting.

Policy Number 300 (Emergency Management Plan) and Policy Number 301 (Emergency Operations Plan) will be an integrated emergency preparedness plan that will have site specific communication plan; emergency officials contact information; methods for sharing information; and documentation that all hospitals within the network participated in the development of the plan.
Person(s) Responsible: Director, Emergency Management
Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

18. The facility did not ensure that an annual door inspection was conducted as required by LCS 8.3.3.1 and the 2010 edition of NFPA 80.

On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the annual door inspection was not completed by 01/01/18 as required by S&C 17-38-LSC; i.e., inspection of stairwell doors, elevator vestibule doors, elevator machine room doors, doors to manifold rooms,, corridor doors to linen chute and was not completed until February 27 2018. Inspected were 65 required Fire Doors with 6 Fire doors passing, resulting in a 91% failure rate of Fire Doors with no repairs completed on the day of survey.

Action Plan: The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will be reduced to once yearly approved by the Environment of Care Committee. The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
7 doors replacement doors were ordered 4/13/18 and parts have been ordered for all other doors requiring repair to rectify the 91% failure rate.
Person(s) Responsible: Director, Engineering Services
Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

19. The facility did not ensure that stairways, elevator shafts, light and ventilation shafts, chutes and other vertical openings between floors were enclosed with construction having a fire resistance rating of at least one hour as required by the referenced "Life Safety Code".

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the annual door inspection of stairwell doors, elevator vestibule doors, elevator machine room doors, doors to manifold rooms, Documentation of the required door inspection showed 65 required Fire Doors were inspected with 6 Fire doors passing, resulting in a 91% failure rate of Fire Doors with no repairs completed on the day of survey

Action Plan: The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will be reduced to once yearly approved by the Environment of Care Committee. The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
7 doors replacement doors were ordered 4/13/18 and parts have been ordered for all other doors requiring repair to rectify the 91% failure rate.
Person(s) Responsible: Director, Engineering Services
Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

20. The facility did not ensure that an annual door inspection was conducted as required by LCS 8.3.3.1 and the 2010 edition of NFPA 80.

On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the annual door inspection was not completed by 01/01/18 as required by S&C 17-38-LSC; i.e., inspection of stairwell doors, elevator vestibule doors, elevator machine room doors, doors to Oxygen trans-filling rooms and manifold rooms, linen chute and trash chute rooms, corridor doors to linen chute and trash chutes and doors to terminus rooms for trash chutes and linen chutes was not completed until February 27 2018. Inspected were 65 required Fire Doors with 6 Fire doors passing, resulting in a 91% failure rate of Fire Doors with no repairs completed on the day of survey.

Action Plan: The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will be reduced to once yearly approved by the Environment of Care Committee. The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
7 doors replacement doors were ordered 4/13/18 and parts have been ordered for all other doors requiring repair to rectify the 91% failure rate.
Person(s) Responsible: Director, Engineering Services

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

21. The facility did not ensure that smoke barriers were constructed to provide at least a one half hour fire resistance rating in accordance with 8.5 as required by the referenced LSC 19.3.7.8,

    On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the annual smoke door inspection of smoke barrier doors, Documentation of the 17 required smoke barrier doors indicated 2 Smoke Barrier doors passed, resulting a 89% failure rate of Smoke Barrier with no repairs completed on the day of survey

    Action Plan: The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will be reduced to yearly once approved by the Environment of Care Committee.
    The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
    7 doors replacement doors were ordered 4/13/18 and parts have been ordered for all other doors requiring repair to rectify the 89% failure rate.
    Person(s) Responsible: Director, Engineering Services
    Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

22. The facility did not ensure that an annual door inspection was conducted as required by LCS 8.3.3.1 and the 2010 edition of NFPA 80.

    On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the annual door inspection was not completed by 01/01/18 as required by S&C 17-38-LSC; i.e., inspection of stairwell doors, elevator vestibule doors, elevator machine room doors, doors to Oxygen trans-filling rooms and manifold rooms, linen chute and trash chute rooms, corridor doors to linen chute and trash chutes and doors to terminus rooms for trash chutes and linen chutes was not completed until February 27 2018. Inspected were 65 required Fire Doors with 6 Fire doors passing, resulting in a 91% failure rate of Fire Doors with no repairs completed on the day of survey

    Action Plan: The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will

be reduced to once yearly approved by the Environment of Care Committee. The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
7 doors replacement doors were ordered 4/13/18 and parts have been ordered for all other doors requiring repair to rectify the 91% failure rate.
Person(s) Responsible: Director, Engineering Services
Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

23. The facility did not ensure that stairways, elevator shafts, light and ventilation shafts, chutes and other vertical openings between floors were enclosed with construction having a fire resistance rating of at least one hour as required by the referenced "Life Safety Code".

    On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the annual door inspection of stairwell doors, elevator vestibule doors, elevator machine room doors, doors to manifold rooms, Documentation of the required door inspection showed 65 required Fire Doors were inspected with 6 Fire doors passing, resulting in a 91% failure rate of Fire Doors with no repairs completed on the day of survey

    Action Plan: The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will be reduced to once yearly approved by the Environment of Care Committee. The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
    7 doors replacement doors were ordered 4/13/18 and parts have been ordered for all other doors requiring repair to rectify the 91% failure rate.
    Person(s) Responsible: Director, Engineering Services
    Completion Date: June 30, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

24. The facility did not ensure that the required automatic sprinkler system was continuously maintained in reliable operating condition and was inspected and tested periodically, as required by section # 19.7.6 of the referenced "Life Safety Code".

    On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Engineering Director-ECHN that identified that the dry pipe sprinkler system covering the Bissell Building when full flood trip tested on 06/19/17 in accordance with and NFPA 25, "Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems" 13.4.4.2.2.2,

results of the testing indicated 2 minutes and 55 seconds of delivery of water to the test port. This time is has not been compared to the original testing times or previous times to determine if there is a problem with the system and as a rule in NFPA 13 "Standard for the Installation of Sprinkler Systems" 7.2.3.2 references 60 Seconds as a design criteria dependent on how this system was designed.

Action Plan: The automatic sprinkler system testing will be completed quarterly to assure reliable operating condition of the automatic sprinkler system.

Fire Protection Testing (vendor) has been contracted to troubleshoot and rectify the sprinkler system dry valve delivery time to assure a dry valve delivery time of 60 seconds.
Interim Life Safety Measures were in place until corrected.
Person(s) Responsible: Director, Engineering Services
Completion Date: April 16, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2)

25. The facility did not ensure that smoke barriers were constructed to provide at least a one half hour fire resistance rating in accordance with 8.5 as required by the referenced LSC 19.3.7.8,

On 03/20/18 at 10:30 AM the surveyor was provided with documentation by the Hospital Emergency Management Director, Engineering Director-ECHN and ECHN Environmental Safety Officer and the Chief Operating Officer - Eastern Connecticut Health Network that identified that the annual smoke door inspection of smoke barrier doors, Documentation of the 17 required smoke barrier doors indicated 2 Smoke Barrier doors passed, resulting a 89% failure rate of Smoke Barrier with no repairs completed on the day of survey

Action Plan: The door inspection will be conducted on a quarterly basis until 100% compliance has been achieved. Once 100% compliance has been achieved the inspection will be reduced to yearly once approved by the Environment of Care Committee.
The door inspection was added to the Life Safety matrix to assure timely assessment of the facility's doors.
7 doors replacement doors were ordered 4/13/18 and parts have been ordered for all other doors requiring repair to rectify the 89% failure rate.
Person(s) Responsible: Director, Engineering Services
Completion Date: June 30, 2018